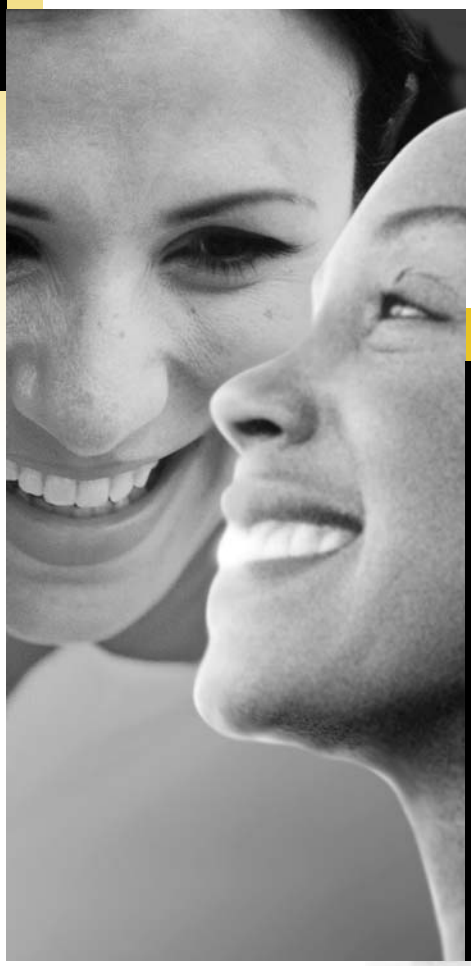
2003

Working Together for Comprehensive Women's Health



A working Conference on the State of Women's Health in New Jersey

Sponsored by:

NJ Department of Health & Senior Services

NJ Public Health Association

NJ Department of Community Affairs, Division on Women

US Department of Health & Human Services, Region II

Office on Women's Health

Southern New Jersey Perinatal Cooperative

Working Together for Comprehensive Women's Health in New Jersey

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Denyse Adler
Linda Anderson
Barbara Andrews
Margaret Copeland
Zupenda Davis
Diane DiDonato
Sandra Estepa
Suzanne Herron
Parvin Ahmad Khanlou
Rosemary Kidder
Lisa King
Peg Knight
Susan Lachenmayr
Geraldine Mackenzie
Bernadette Marin
Sindy Paul
Kathleen Russo
Doreleena Sammons-Posey
Shirley Smith
Carol Vasile

May 14, 2003

A working conference on the state of women's health in New Jersey sponsored by:

NJ Dept. of Health & Senior Services; NJ Public Health Association; NJ Dept. of Community Affairs, Division on Women; US Dept. of Health & Human Services, Region II; Office on Women's Health; and the Southern New Jersey Perinatal Cooperative

PROCEEDINGS

WORKING TOGETHER FOR COMPREHENSIVE WOMEN'S HEALTH

A Working Conference on the State of Women's Health in New Jersey

Presented by the Office on Women's Health
New Jersey Department of Health and Senior Services

May 14, 2003

Peri L. Nearon, MPA
Coordinator, Women's Health
Division of Family Health Services
New Jersey Department of Health and Senior Services

WORKING TOGETHER FOR COMPREHENSIVE WOMEN'S HEALTH
A Working Conference on the State of Women's Health in New Jersey

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EXECUTIVE SUMMARY

While the life expectancy of women in the United States has nearly doubled in the past 100 years, women do not necessarily experience good physical and mental health throughout that extended lifespan. Although significant progress has been made in past decades, many women continue to suffer from inadequate access to high quality health care, provider bias in the type of treatment options offered and a lack of comprehensive health care services throughout their life cycle. Women face a major and compelling challenge as the chief navigators of the health care system for their extended circle of family and friends, *and* themselves. Many women also serve as health care professionals and volunteers. As a result of this special perspective, women have provided a major impetus for health care reform and improvement throughout the last century.[1]

In New Jersey, consistent with the rest of the country, considerable advancements have been made in addressing the concerns of women and health care delivery. Nonetheless, women continue to be faced with a health care system that is often fragmented and inaccessible, and lacking a focus on comprehensive primary and preventive services. A large number of women are uninsured or underinsured, lack basic enabling services such as transportation and child care, and interact with providers that may lack competence regarding cultural, racial/ethnic, language and religious traditions that impact on health behaviors and understanding. These factors directly influence the state's ability to significantly reduce/ eliminate health disparities among its' diverse population groups.

Focusing on the Problem:

The current efforts to establish an Office on Women's Health were initiated a decade ago. The first New Jersey Women's Health Summit was held in September 1993. To focus attention on the need for action and advancement in women's health, Public Law 2001, Chapter 376, signed in January 2002, established the Office on Women's Health in the Department of Health and Senior Services. (See Appendix I) The Office on Women's Health (NJOWH) is located in the Division of Family Health Services.

Modeled on the national Department of Health and Human Services Office on Women's Health, the New Jersey office was mandated to serve as a focus to advance women's health, coordinate information and resources, advocate for women's health needs, and to provide information and outreach. In addition, the office was charged with:

- Developing a diverse and collaborative public/private model for policy direction;
- Providing grants for research and demonstration projects;

[1] The Honorable Patricia Schroeder, "The History and Future of Women's Health, June 11, 1998 (www.4women.com)

- Designing and implementing educational programs; and
- Establishing a Women's Health Advisory Commission

As the first action of the new Office on Women's Health, a diverse group of women's health professionals and advocates were invited to consider the initial priorities for the new office. On May 14, 2003, 120 participants gathered to consider "Working Together for Comprehensive Women's Health." From the plethora of pressing issues for women, six topics were selected for preliminary discussion. These topics included:

- Maternal and Child Health
- Health Promotion
- Chronic Illness
- Addictions, HIV/AIDS, Sexually Transmitted Disease
- Mental Health
- Violence Against Women

Armed with information about women's national, regional and state health status and priorities, participants were asked to consider the specific challenges, resources and policy advancements needed to address these six concerns. Acknowledging that a one-day conference could not possibly incorporate the full range of issues, the participants accepted the task of identifying the most pressing concerns.

Barriers and Obstacles

While recognizing the significant advances that have been made, the robust and wide-ranging discussions touched on the continuing obstacles to achieving comprehensive health care for women and girls of all ages. The barriers identified include:

- A lack of long-term strategic planning;
- The absence of specific and timely data needed for planning and outcome evaluation;
- Limited resources for enabling services such as transportation, translation, and child-care;
- The confusion created by the need for separate applications and visits to several different agencies to obtain comprehensive care;
- A dearth of communication between relevant agencies serving the same population;
- The insensitivity to cultural, racial, religious, language and ethnic differences often encountered;
- The lack of insurance or documented legal immigrant status.
- Inadequate educational efforts that are often poorly directed for the target audience;
- Myths and misperceptions preventing a common understanding of violence, wellness, health, well-being and other essential concepts;
- Medical treatment decisions often derived from clinical studies included only men, although efforts now underway to expand research targeted specially to women and minority populations. It was noted that health disparities persist among minority populations regardless of education, socioeconomic level or insurance status;[2] and

[2] Institute of Medicine, "Unequal Treatment: Confronting Race and Ethnic Disparities in Health"

- Scarce gender specific services, as well as those that recognize the distinct needs of older women, the disabled, adolescents, children, and those with alternative life styles.

Policy Recommendations:

The proceedings of the Working Together conference provide an expansive list of policy recommendations and action steps. Specific recommendations for policy development and action steps for each health care issue are discussed in the Proceedings of the Conference. A number of overarching themes emerged for policy and action priorities.

- *Services and programs should be designed to be comprehensive and easily accessible.*
  The development of a single application form that could be used for multiple agencies would help to facilitate access to services and reduce confusion. The establishment of service sites that provide multiple varied programs in one location would enhance communication and coordination of care. Comprehensive directories and referral to local and accessible providers is essential. Transportation, childcare, translation, and extended hours, as well as assistance in navigating the system are critical components to providing meaningful access.

- *All services and programs should be culturally competent and linguistically appropriate.*
  Program staff and outreach workers that mirror the populations they serve, as well as educational materials and programs delivered in the languages most easily understood to clients, are essential. Responsive care includes respect for cultural diversity and alternative lifestyles. Ongoing training for all health care providers and volunteers in understanding and valuing cultural diversity will ensure a more effective outcome, reducing health disparities and promoting utilization of services.

- *Women should have a voice in determining how their own needs will be met.*
  Focus groups and community organizations would enable women to identify their specific needs and to advocate for their inclusion in the design of health care and social services in the State.

- *Women need easily accessible care and broad comprehensive services that will:*
  - *Ensure freedom from violence*
  - *Provide programs to reduce the development and toll of chronic diseases, and*
  - *Assist women to maintain general well being.*

  Enhancing services to the uninsured, underinsured, Medicaid, immigrant and/or undocumented populations is critical to ensuring this comprehensive care.

- *Mental health should be fully integrated into the delivery of care throughout the life span.*
  Enhanced collaboration and communication between physical health and mental health providers will ensure more comprehensive and effective health outcomes.

- *Educational and outreach programs that provide accurate and timely information, dispel myths and misperceptions and empower women to advance their own, and their families' health status, should be designed and implemented for consumers and professionals.*

  Educational materials should be targeted to specific populations, beginning with young children, and address each phase in the life span. Innovative educational materials should be designed to be easily understood and relevant to women's lives. Programs and materials should reach women where they live and congregate, including faith-based, community and work settings. Education can dispel myths about such topics as violence, addiction, mental health, abuse and reproductive health and bring these into the mainstream for consideration.

- *Timely, accurate and comprehensive data should be collected and analyzed for strategic planning, program evaluation and outcome assessment.*

  Information critical to strategic planning and effective long-term accountability should be identified and collected in a timely fashion. Resources for this effort are essential. All data collection should be designed to ensure privacy and sensitivity and be clearly described to participants.

- *Gender specific research is essential to ensuring effective and successful treatment planning.*

  Women and minorities have been significantly under-represented in clinical trials to determine new treatment options. Consequently, researchers should be encouraged and funded in the development of studies relevant to women's health, minority health, chronic illness, the long-term impact of abuse and violence, healthy life styles and other issues of immediate concern.

- *Collaborative partnerships should be established among governmental, non-profit and the private sectors to maximize resources and accelerate progress toward the goals.*

  An inclusive approach incorporating existing agencies, professionals, and consumers will motivate participation and ensure that resources are most effectively used. Advocacy for necessary changes in legislative and regulatory policies will move the agenda forward, and help to acquire more universal health care for underserved populations. Men should be invited to participate in all of the priorities of women's health care.

The Next Steps

The conference provided an initial opportunity to focus on the challenges and priorities in meeting the health needs of women in New Jersey. Moving the agenda forward can only be accomplished through the energetic, enthusiastic and wholehearted participation of *every* agency, organization and individual in the State. The New Jersey Office on Women's Health will serve to coordinate, collaborate and motivate progress in accomplishing these goals. However, there are many ways for the process to begin in the community. Each organization can:

- Review its own programs and policies in light of the barriers identified and adapt responsive training and services;
- Volunteer to participate in one of the many NJOWH Task Forces and other collaborative efforts to address critical issues; and

- Engage legislative, governmental and regulatory bodies in discussion about how to extend coverage for health care, develop necessary resources and to begin to achieve the important health care goals.

The future of women's health, and by extension, all health care in the State requires a collaborative and focused effort. This conference is the first step in achieving that goal.

PROCEEDINGS

WORKING TOGETHER FOR COMPREHENSIVE WOMEN'S HEALTH
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May 14, 2003

"The years of hard work and struggle have led to some triumphs, but we also have to think about how far we have not come, and how much is left to do to improve the health, status and well-being of American women"[3]
The Honorable Patricia Schroeder

Women have traditionally been the primary caregivers and decision makers on health issues for their families, as well as the caregivers for ill or disabled family members. Although women are an increasingly significant force in the business, education, government and health care workplace, others live in poverty, undocumented status or are isolated in old age. Women are often required to juggle the health needs of children, spouses/partners, parents, grandparents, and, if there is time, themselves.

Women face many challenges in their attempt to navigate and reform the health care system in the United States. These concerns have broad implications for the future of the nation's children, the economic viability of the workforce, and the care of the oldest and most vulnerable citizens. Services can be severely fragmented and enormously variable in access, quality and responsiveness. The "information age," initially seen as a boon to those in need of timely and accurate information, can instead create an overload of conflicting and incoherent data. Resources are often scarce or nonexistent and support can be difficult to find.

Despite their role as the health "gatekeepers," women (especially minorities and immigrants) are often treated differently in the health care arena; they may receive less thorough evaluations for similar complaints, have their symptoms minimized, receive fewer options for interventions for the same diagnoses, and obtain fewer or less satisfying explanations in response to questions.[4] Research focused on women has been traditionally confined to reproduction and fertility, while studies on many other health care concerns included only men, consigning women to receive treatments whose success was only evaluated for men. Large governmental budget shortfalls and an increasing number of uninsured and undocumented people in the country present additional hardships in obtaining access to care.

[3] Schroeder, 1998
[4] Weissman C, Two Centuries of Women's Health Activism, Women's Health Care: Activist Traditions and Institutional Change, Seminar Highlights, Department of Health and Human Services, (DHHS) Office on Women's Health, June 11, 1998

In response, women have assumed the role of health reformers, adopting health issues as the focus of organized social movements in the country since the 19th century.[5] They have become activists, creating new services where none existed, insisting on care for their children and families, and incorporating health goals into their social and educational efforts.

Why a focus on *Women's* Health?

The special health needs of minorities, low-income, older, disabled or especially vulnerable groups present a complex and often overwhelming challenge, which women face in disproportionate numbers. In New Jersey, almost eight percent of women live in poverty, and nearly twelve percent are without health insurance. Heart disease, cancer and stroke are the leading causes of death among women in the State, much of which could be detected and treated if diagnosed early.[6] Both sexes are subject to the ravages of major chronic and acute illnesses, such as Alzheimer's, heart disease, and cancer, and suffer from lack of broad, universal access to health care. However, some of the special challenges women face impose a greater toll for them, including (partial list):[7]

- ***Autoimmune diseases****:* 75% of these diseases occur in women, including systemic lupus erythematosus, rheumatoid arthritis, multiple sclerosis, scleroderma, chronic fatigue syndrome, Graves disease, and fibromyalgia.

- ***Cancer****:* Cancer is the second leading killer of American women. Lung cancer mortality is increasing among women while declining among men. Women now have a one in eight lifetime probability of contracting breast cancer, while mortality from cervical, ovarian and colorectal cancers continues.

- ***Osteoporosis:*** 80% of those affected are women and the disease often results in bone fractures and loss of mobility and activities of daily living. Half of all women will have an osteoporosis fracture in their lifetime.[8]

- ***Arthritis*****:** Women age 15 years and older account for 60% of this diagnosis, about two to three times as many women as men, and arthritis is the leading cause of disability in the US.[9]

- ***Heart Disease*****:** Although men are more often diagnosed with heart disease, more women die of this disease than men. More than one in five women has some form of major heart or blood vessel disease, one in four over the age of 65. In New Jersey over 20% of women have hypertension.

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[5] Reynolds S, "Women's Health Movement from 1960's to the Present and Beyond", Seminar Highlights, DHHS Office on Women's Health, June 11, 1998

[6] Andriot Wood C "Women's Health: New Jersey's Perspective, Working Together for Comprehensive Women's Health, Office on Women's Health NJDHSS, May 14, 2003

[7] Women's Health Statistical Information, The National Women's Health Information Center, US Department of Health and Human Services, Office of Women's Health (www.4women.com)

[8] New Jersey Department of Health and Senior Services, Osteoporosis, www.state.nj.us/health/senior/index.shtml.

[9] Centers for Disease Control and Prevention "Prevalence of Self Reported Arthritis or Chronic Joint Symptoms Among adults," MMWR, 2002;51(42) 948-950

- ***HIV/AIDS**:* This epidemic is a rapidly growing problem among women, especially in New Jersey, which has the highest proportion of women among AIDS cases in the nation.

- ***Depression and Suicide*:** Nearly twice as many women as men are affected by a depressive disorder each year. Depression occurs most frequently in women age 25 to 44. Fewer than half the women who experience clinical depression will seek care. Three females attempt suicide for every male attempt; often the cause is an untreated mental illness, particularly depression.[10]

- ***Geriatric care***: Nearly 24 million women in the United States are age 65 or older and that number is expected to double over the next decade.[11,12] Women 85 or older make up the fastest growing segment of the population; 87% of them live alone and are likely to be living in poverty. Over 53% of women age 60-69 only exercise rarely and 80% of those age 65 and older have at least one chronic disease, with half reporting two or more chronic diseases.[13]

- ***Cigarette Smoking***: More than 22% of adult women and about 17% of pregnant women aged 15-44 smoke. In 1999, almost 35% of high school girls were smoking.

- ***Eating disorders, teen emotional health and teen pregnancies***: Females are much more likely than males to develop eating and anxiety disorders. Younger women are particularly at risk for reproductive health problems associated with sexually transmitted diseases.

- ***Domestic violence and sexual assault***: More than 95% of victims of domestic violence and sexual assault are women. One out of four American women reports having been raped and/or physically assaulted by a current or former spouse, live-in partner or date at some time in their lives.[14]

- ***Urinary Incontinence***: Women experience the impact of this health problem on daily living two times more often than men.

- ***Minority Health:*** Poorer health outcomes and differences in health access, diagnosis and treatment options are reported among minorities, regardless of income, education or insurance status. This is well documented by the Institute of Medicine.[15] Minority women receive fewer preventive health interventions than white women, including Pap tests,

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[10] Indart, M, "Women and Well-Being: Mental Health Issues of the 21St Century," Mental Health Working Group, Office of Women's Health, NJDHSS, May 14, 2003

[11] Federal Interagency Forum on Aging-Related Statistics, *Older Americans 2000: Key Indicators of Well-Being,* http://www.agingstats.gov/chartbook2000/population.html

[12] Office on Women's Health, U.S. Department of Health and Human Services, *Older Women's Health in the National Centers of Excellence in Women's Health, May 2000.*

[13] Omenn, G. (2001). *Healthy Aging: Preventing Disease and Improving Quality of Life Among Older Americans*. Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion. Atlanta, Georgia.

[14] Patricia Tjaden & Nancy Thoennes (1999). Prevalence, Incidence, and Consequences of Violence Against Women: Findings from the National Violence Against Women Survey. National Institute of Justice and Centers for Disease Control, Washington, DC (NIJ Grant #93-IJ-CX-0012). Available from the US Department of Justice's Violence Against Women Office.

[15] Institute of Medicine, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health"

mammograms and blood pressure screening. Stroke occurs at a higher rate among African American and Hispanic women compared with white women. In New Jersey, life expectancy for African American women is seven years less than for a white woman.

The Federal Response to Women's Health

In 1991, in response to these urgent needs, the federal Department of Health and Human Services (DHHS) established The Office on Women's Health (OWH) to improve the health of American women by advancing and coordinating a comprehensive women's health agenda throughout all federal agencies. The goal of the office is to address health care prevention and service delivery, research, public and health care professional education, and career advancement for women in the health professions and in scientific careers. By working collaboratively with numerous government agencies, non-profit organizations, consumer groups, and associations of health care professionals, the effort established women's health firmly in the national health landscape. The office is now able to focus more directly on specific women's health priorities to meet the pressing demographic trends of the next century and the millions of underserved women in the country.

The mandate of the federal Office on Women's Health includes a special focus on the social and cultural barriers limiting access of minority women to the health care system. Those identified include:

- Lack of culturally appropriate services
- Inadequate child care and transportation
- Distrust of the system, which may be perceived as hostile and insensitive
- Racial, ethnic, gender and other forms of discrimination
- Language and religious differences in approaching health care
- Lack of insurance coverage.

The goals of the OWH are met through federal initiatives and with the assistance of ten Regional Women's Health Coordinators who are charged with working closely with the agencies and institutions within each region to promote the national goals.

New Jersey's Response to Women's Health

The challenges women face in New Jersey mirror those of the national picture. Of the more than four million women in the State, almost eight percent live in poverty, and nearly twelve percent are without insurance. The ethnic diversity of the State is perhaps among the most complex in the country and many women face the burdens of greater longevity without adequate resources. The State has the highest rate of women with AIDS in the nation, and experiences rates of chronic disease, domestic violence and perinatal risks consistent with the national statistics. Goals for the amelioration of many of these health care risks are established in Healthy New Jersey 2010, the DHSS blueprint for health care through 2010. A broad collaboration of governmental, public and private agencies initiated a number of innovative and successful efforts to address health threats. However, as with the national scene, these efforts may be fragmented within specific agencies and lack visibility and coordination.

The current efforts to establish a New Jersey Office on Women's Health are built on the activities of women in the State a decade ago. The first New Jersey Women's Health Summit was held on September 10, 1993. This working meeting was charged with developing a series of recommendations on issues pertinent to the health of women in New Jersey.

To highlight the special health needs of women, Public Law 2001, Chapter 376 was signed in January of 2002, establishing the Office on Women's Health in the Department of Health and Senior Services. (See Appendix I) The Office on Women's Health (NJOWH) is located in the Division of Family Health Services and is designed to serve as a focus to coordinate services, advocate for women's health needs, and to provide information and outreach to ensure a private/public partnership to improve access to services. The role of the Office is to develop a collaborative model within relevant departments in the State and with public and private agencies and others interested in advancing the agenda of women's health. In addition, the Office was mandated to:

- Provide grants to community-based organizations for special research, demonstration and evaluations projects;
- Design and implement health awareness campaigns, and improve access, acceptability and use of public health services;
- Serve as an information and resource center;
- Establish a Women's Health Advisory Commission of nine members to fulfill the mission of the Office, make recommendations on policy, advise on awarding of grants and the development of programs and services, and to support the investigation into the needs, priorities, programs and policies relating to women's health in New Jersey;
- Convene Task Forces of experienced, knowledgeable persons on specific issues as appropriate;
- Prepare an Annual report to the Legislature and Governor identifying the activities of the Office and any recommendations for the administrative or legislative action deemed appropriate.

A committee representative of public and private health care agencies was established, and began to deliberate on the most effective means of launching the NJOWH. The "Working Together" conference was designed to foster a full discussion of significant health issues for women in New Jersey, and to identify priorities for an action plan for the Office.

In March 2003, Peri L. Nearon, MPA, was appointed the first Coordinator of Women's Health and on May 14, 2003 the "Working Together for Women's Health" conference was convened to consider the future course of the Office.

"WORKING TOGETHER FOR COMPREHENSIVE WOMEN'S HEALTH"

ACTION PLAN

The diverse group of participants invited to the "Working Together for Comprehensive Women's Health" conference were charged with identifying priorities for developing an action plan to address an initial group of six major health challenges identified by the conference planning committee as appropriate starting points for the efforts of the NJOWH. These six issues were:

I. Maternal and Child Health
II. Health Promotion
III. Chronic Illness
IV. Addictions, HIV/AIDS, Sexually Transmitted Disease
V. Mental Health
VI. Violence Against Women

Bolstered by expert presentations within each workshop, (See APPENDIX II Agenda), the participants were asked to provide an initial attempt to: outline the major problems and gaps in services; describe some existing resources and information; gain consensus on at least three initial goals for the NJOWH; and identify specific action steps to achieve the goals. This ambitious agenda provided the framework for the day and generated a robust discussion of the complex issues.

I. MATERNAL and CHILD HEALTH

Maternal and Child Health (MCH) is a broad, global topic that in many ways transcends and encompasses many of the issues critical to the overall health of women. Presenters and participants focused on health care needs from prenatal care throughout the life span, and identified those issues considered most significant, and those on which the Office on Women's Health might focus as priorities.

Problems:

- *Service concerns*:
  The considerable fragmentation of services creates special problems in light of the lack of stability in many women's own lives.

- *Immigrant issues*:
  The fears of undocumented women, as well as the lack of insurance and familiarity with the system create a reluctance to seek appropriate preventive and treatment services, even when such services exist.

- *Enabling services*:
  Transportation, translation, employment assistance, accommodation for disabilities, expanded and accommodating hours, and childcare are critical services to permit women to benefit from available programs, even when such

programs are offered. Many women lack access to technologies for information gathering, including telephones and Internet access.

- *Insurance concerns*:
  For uninsured and underinsured families, facing the complexities of uncompensated care and changes in coverage, as well as the difficulties in negotiating the managed care "maze," can exacerbate health problems. These obstacles can result in care that is often too little, too late. Few third party funds or resources are available for high-risk pregnancies among the uninsured or undocumented.

- *Cultural competence and disparities in health care services:*
  The complexities of diverse cultural traditions and beliefs, the lack of translation and appropriate materials (language and literacy) provider bias, and frequent insensitivity to racial and ethnic cultural differences create significant barriers to effective utilization of health care. Women often perceive institutional racism and negative provider attitudes, which serve to prevent full participation in beneficial programs. Government programs should expand beyond poverty alone and begin to address working-poor and middle income minority families who experience poor health. Lack of access and poorer outcomes among minorities are well documented.

- *Specific gender-related problems:*
  Women need appropriate screening for high-risk behaviors such as substance abuse and unsafe sexual behavior, as well as protection from secondary smoke that many encounter in the workplace. Many women are isolated due to language, economic status or the stresses of managing family and work, and need the support of the community, including male involvement.

- *Awareness and availability of resources:*
  Often women are not made aware of the resources available to them in a timely manner. Women gain information where they live: churches, social organizations, workplace and schools. Relevant information should be made easily obtainable, but more important, women should be encouraged to take the time to learn about and avail themselves of important prevention and early detection practices. For many women, this is not a priority in the stresses of everyday life, a factor that should be understood in developing an action plan.

Resources:

A number of key resources, although not an exhaustive list, are included in Appendix III.

Policy Recommendations:

The participants considered a long list of important recommendations to improve the health of women and children. Consensus was gained on three initial steps:

1. *Develop one comprehensive application for services* that establishes eligibility for entitlement and benefit programs. This would encourage individuals to participate in several programs and eliminate the burden of redundant, time consuming and discouraging multiple trips and applications. The single application could apply to: Medicaid, Temporary Assistance for Needy Families (TANF), Women, Infants and Children (WIC), NJ Family Care, Food Stamps, and uncompensated care, to name a few. This approach could adopt the "smart card" technology.

2. *Promote and provide incentives for providers to collaborate in a single facility* with expanded hours, in which multiple services could be provided, including: supportive and counseling services, eligibility determinations, and health services. Such facilities could include uniform screening of all women for substance abuse, domestic violence, and HIV. Both insurers and consumers would accept responsibility and accountability for the success of such ventures.

3. *Use representative focus groups and outreach to identify the specific needs of women,* and challenge organizations and service agencies to adapt to these consumer needs by developing and implementing responsive services.

Additional recommendations:

- Expand the focus of government programs to a broader outline, moving from poverty as the single criteria, to eliminating disparities among minorities and improving health outcomes.
- Develop a broad collaboration to represent women's health issues on commissions and advisory groups including those outside of the health care arena (banking, insurance, auto industry, etc.). Working and unemployed women of all ages and cultures should be included.
- Acquire and analyze New Jersey specific data to ensure that policies are evidence and science based.
- Educate employers in New Jersey about the benefits to them and their employees of policies that accommodate women's need for prenatal and well childcare.
- Adopt policies that support comprehensive teen pregnancy prevention and parenting services and education.
- Provide comprehensive, easily accessible care and model programs for substance abusing women, and their children, as appropriate.
- Focus on the development of programs and services that promise a long-term impact on the health of women and children.
- Require providers to have ongoing staff education about cultural and linguistic competency skills, and consider the use of certification tied to licensure.
- Develop a broad campaign to encourage and provide "permission" to women to make time for their own care.
- Encourage new and ongoing support groups and respite care for mothers/families with special needs.

Action Steps:

- Reduce the redundancy in care by coordinating existing resources to prevent a patchwork system. To the extent possible, promote uniformity in records, programs, and requirements.
- Promote education relative to the need for prevention and detection of disease including the value of routine mammograms, Pap smears, cardiovascular disease testing, and early and continuous perinatal care.
- Decrease barriers to care by tailoring needs and projects to specific populations to address health care needs and include these requirements in Requests for Proposals for grants.
- Support collaboration and sharing of resources at the municipal and community level to accommodate a more specific needs assessment and data collection effort.
- Upgrade data systems in hospitals and local health departments to provide easily accessible web-based technology.

II. HEALTH PROMOTION

Health promotion is a broad topic that might encompass an array of issues from generalized well-being, to exercise, nutrition, obesity and other lifestyle issues. It has been acknowledged that positive body image and a healthy mental attitude play an important role in wellness. Despite the acceptance of this concept, a number of problems were identified in the attempt to deliver the message of the importance of healthy living.

Problems:

- *Data*

  Information and data collection has not been comprehensive or timely, and does not provide a full picture of individual practices and informational needs.

- *Research*

  Credible information is needed to design effective and successful methods of delivering the message about the importance of the adoption of healthy lifestyles. For example, while obesity is recognized as an epidemic health problem, little has been accomplished in addressing it.

- *Education*

  Discussion about health promotion is often confusing; for example, the meaning of "regular exercise," "recommended intake," and other terms is interpreted differently among diverse populations and age groups. Education should be used to offset advertising that highlights "beauty" over healthy living and other messages that promote high calorie, poor lifestyle choices.

- *Access*

  Resources are often not linked to those who need them the most. Costs of exercise facilities, healthy diets and other services may be prohibitive to some. Facilities for promotion of healthy living may not be easily accessible and targeted to the population most in need.

Resources:

Resources to promote healthy living and adoption of appropriate life styles include federal, state and local agencies, non-profit organizations, community schools and private gyms. Corporate wellness programs and local public health officers are becoming more attuned to the need to promote wellness. A list of some relevant resources can be found in Appendix III.

Policy Recommendations:

1. *Design an educational campaign* to overcome the widely held belief that healthy eating, exercise and attention to wellness takes too much time from busy schedules.

2. *Promote the public perception of the benefits of physical activity*, good nutrition and avoidance of obesity. Health promotion programs need to address women of all ages including older adults. Behavior change at any age can have a tremendous impact; even the very old can become physically fit, have better function and live longer.

3. *Expand data collection to reflect actual practices*, needs and experiences of the public relative to healthy lifestyles. Expand the Behavioral Risk Factor Surveillance Survey (BRFSS) to include specific populations not currently sampled, designed to account for language and cultural differences. Partner with academic institutions and state funding agencies to develop Requests for Proposals that incorporate health promotion.

Action Steps:

- Develop a coordinated, unified message about healthy living and utilize the new NJOWH, public health agencies, foundations, organizations and other resources to get the message out.
- Promote a healthy lifestyle campaign though school initiatives and intense parental involvement.
- Ensure that all materials and messages are provided in clear, culturally competent and linguistically appropriate, easily understood formats directed to each specific population.
- Provide Internet accessible information by allocating space on the DHSS web site for delivery of healthy living messages.
- Ask the Governor and/or his wife to become spokespersons for the messages, in concert with the focus both the President and Governor have placed on fitness.
- Advocate for quality standards to be established for all recreational and physical fitness facilities in the State.

III. CHRONIC ILLNESS

Chronic illness is defined as a group of health conditions that may last over time, may produce frequent or periodic recurrence, and which can have a significant impact on activities of daily living and general well-being. Women often experience chronic illness in disproportionate numbers, and are also the "gatekeepers" who assume responsibility for the care of their (often extended) families. Consequently addressing the issues related to chronic illness is a pressing concern to women. A number of significant problems emerged from the robust discussion of the impact of chronic illness on women.

Problems:

- *Access*

  Many women cannot access health care across the life span as a result of their uninsured status and the limited number of providers in some areas. Patients need access to home health care, respite care and hospice as appropriate, to assist individuals in maintaining independence and autonomy. Funding is lacking for primary care prevention and professional and public education.

- *Attitudes*

  Some of the attitudes discussed included:

  - The considerable misunderstanding about the nature of chronic illness and the role and responsibility of the individual in self-management. Women often avoid placing importance on their own health care; they should be encouraged to make their own health a priority.
  - The need to consider quality of life as an important outcome of treatment.
  - Providing appropriate care for lesbians, who are often excluded from routine health care, for example, in the mistaken belief that they are not considered at risk for cervical cancer. They often do not get HIV education/testing, and are not considered at risk for domestic violence.

- *Patient partnership*

  Patients/consumers need to understand clear guidelines for managing their disease. The family should be considered partners in the management of chronic disease. Information about health should be delivered in simple, understandable terms that provide education in the individual's own language and cultural terms. Alternative therapies should be discussed and evaluated for each individual.

- *Research*

  Myths abound about the role of screening and detection in diagnosing chronic illnesses and more clear information is needed. More research and information is needed about the potential link between chronic illness and violence and depression.

- *Education and Cultural Competence*

  Medical staff and personnel should mirror the constituency they serve, to the extent possible; education about specific cultural groups should be provided to all caregivers.

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Resources:

The Chronic Illness Working Group identified the need to develop a directory and catalogue of resources that are specifically geared to chronic illnesses.

Policy Recommendations:

1. *Advocate for health insurance for all women across the life cycle.*

2. *Support development of culturally competent curricula and continuing professional education* programs that focus on chronic health issues, including information about women with disabilities, alternative lifestyles, ethnic and linguistic differences.

3. *Promote a public awareness campaign that focuses on culturally competent women's health issues* and provides clear and understandable information to the media about chronic health issues.

Action Steps:

- Motivate and encourage a broad range of women's organizations and individuals in the community to advocate for women's health, especially by women who are elected officials, women's clubs and organizations, disability organizations, county commissions on women, offices on multicultural affairs, faith-based organizations, health care facilities, community centers, Federally Qualified Health Centers, and not-for-profit and professional groups.
- Identify and evaluate "best practices" in the delivery of women's health care.
- Develop materials to facilitate professional education about chronic illness, including written, video, interactive CD-rom and other innovative technologies.
- Expand available information and data about chronic illness in women, and update Healthy NJ 2010, especially in areas not currently covered.
- Advocate for a collaborative, case management approach among primary care and specialty providers that will reduce the fragmentation of care and coordinate services.
- Establish a coalition that explores partnerships with community organizations, health care facilities, county commissions and other interested groups/individuals.
- Design and coordinate a "clearinghouse" for public and professional information, to be easily accessed through a toll free telephone number, web site, catalogue and print materials.
- Coordinate with the New Jersey Easy Access Single Entry (NJ EASE) system, designed for older women, to distribute information.
- Develop newsletters, bulletins or other regular publications to disseminate information about women's health and highlight "best practices."

IV. ADDICTIONS, HIV/AIDS, SEXUALLY TRANSMITTED DISEASES

These three major topics were included in one workshop as a consequence of several overarching commonalities. However, each specific topic required separate consideration for problem identification and action planning. The discussion of addictions included a broad range of addictive behaviors, including smoking, dangerous substances, and other high-risk behaviors. The rapidly accelerating growth of AIDS among women in New Jersey, as well as the significant problem of Sexually Transmitted Diseases (STD), was a major concern to participants.

ADDICTIONS

Problems:

- *Enabling Services*

  Transportation, short-term childcare and housing for women while undergoing rehabilitation are scarce, preventing broader participation. Little follow-up is provided to those who do enter programs.

- *Access*

  Many women lack insurance to cover costly rehabilitation or medical services, and consequently return to reliance on substances. Often women in need, and the health professionals providing care, are not aware of even those services that are available. No central directory of services and programs is available in the State. Fear of loss of confidentiality (even with new Health Insurance Portability and Accountability Act [HIPAA] restrictions) prevents utilization of services.

- *Attitudes*

  Often addictive behavior is related to low self-esteem and lack of supportive environments. In addition, the pressures of the culture in which the individual functions may increase these high-risk behaviors. Language barriers, racial or ethnic discrimination or attitudes of health care workers or child protective services may encourage women to avoid confronting or acknowledging their problems.

- *Philosophy and Long Range Plans*

  The lack of an overriding philosophy or long range plan for prevention, treatment and care of addicted women has impeded the growth of funding and innovative approaches for specific programs and services. Timely data and research are needed to identify, disseminate and monitor best practices. Agencies should develop quality assurance criteria and practices.

Resources:

Although existing resources were considered vastly inadequate for the need, many programs are available and can provide a range of services. These are provided on the regional, state, county, and local levels. Some specific resources are identified in Appendix III.

Policy Recommendations:

1. *Develop a long-term strategic plan for prevention and treatment* that provides innovative approaches and timely, comprehensive and easily accessible data with which to identify populations at need and effective practices.

2. *Establish gender-specific, well-funded programs* that focus on and target specific women's issues and needs.

3. *Provide a "single point of entry" approach* that ensures a comprehensive and coordinated approach to reduce fragmentation and gaps. Consider the NJ EASE model for replication.

Action Steps:

- Review existing and newly proposed programs for ease of access and comprehensive delivery of services in a single location.
- Initiate strategic planning utilizing the input of experts and incorporating relevant stakeholders in the discussion. This should be a role of the new Commission on Women's Health.
- Develop a navigation system to assist women in identifying and participating in services and programs in the community.

HIV/AIDS AND SEXUALLY TRANSMITTED DISEASES (STD)

Problems:

- *Education*

  Consumers, patients and health care providers are poorly informed about the specifics of HIV/AIDS and STD prevention and treatment. Comprehensive sex education for young people is lacking; some schools stress or discuss only abstinence. Funding is lacking for broad scale educational programs. Faith-based programs also need information and education.

- *Screening and Testing*

  People are not aware of the need for early testing and are concerned about confidentiality laws and the potential for abuse of the information. Many factors prevent individuals from obtaining testing for HIV; among them are fear of the outcome of the test and the lack of easy access to rapid report HIV testing. Current rules permit only licensed laboratories to run such tests. Individuals with a positive test result are not provided with enough information on preventing transmission of HIV. Standards on informing women and youth on STD's are lacking.

- *Treatment*

  Access to prevention aids, medication and treatment is not universal, and best practices have not been identified. Effective treatment for resistant organisms is problematic and needs additional research.

- *Attitudes*

  People still perceive a stigma attached to HIV and STD, and this prevents participation in prevention, testing and treatment programs. Education of the public is needed to addresses these attitudes.

Resources:

While services for HIV/AIDS have expanded during the past ten years, programs specially targeted to women are lacking and represent a significant need. (See Appendix III)

Policy Recommendations:

1. *Establish a strategic planning process* including relevant agencies, individuals and stakeholders that will ensure comprehensive, easily accessible education and services to address HIV/AIDS and STD needs. The process will require data and analysis to ensure the most effective approaches.

2. *Develop an educational approach* targeted to each age group. Start the program for young children in school and continue throughout the life cycle. Ensure that materials and delivery are culturally and linguistically competent and address all socioeconomic, literacy and age groups. Provide education for health care providers and promote inclusion of risk factors for STD and HIV in the history and physical.

3. *Expand existing programs and initiate new ones to ensure broad access to prevention and treatment* including distribution of condoms and needle exchange. Advocate for amendment of current New Jersey laws regarding confidentiality to allow providers to provide more effective discussion of the patient's status and services available.

Action Steps:

- Include relevant stakeholders in the strategic planning process under the aegis of the Commission on Women's Health.
- Collaborate with the Department of Education to ensure that current sex education curriculum is relevant, clear and well articulated for young children through young adults.
- Advocate for legislative changes to provide for essential services, programs and changes in the confidentiality laws to promote more effective services, as well as permitting condom distribution.
- Train providers and promote easier access to rapid and accurate testing and counseling services for HIV and STD.
- Promote high standards and quality of care for HIV/AIDS and STD patients.

V. MENTAL HEALTH

Mental health concerns and concepts have not been fully integrated into the consideration or delivery of general health care in New Jersey. Although mental health is inextricably linked to well-being and general good health, and can often be a predictor of physical health outcomes, it lacks the recognition and funding that physical health receives.

Problems:

- *Understanding of mental health*

  Mental health concepts are still not clearly understood by both the public and health care professionals. The line between appropriate "phase of life" development and mental health problems is poorly described. Myths and misunderstandings relevant to mental health continue to create stigmas and encourage individuals to conceal their difficulties.

- *Education*

  Targeted education is needed for the public and for healthcare providers to overcome stereotypes and to ensure an open approach to mental health. Primary care physicians and other health providers especially need specific information and training. Mental health educators are needed to disseminate information and provide ongoing education and training. Advocacy skills should also be taught to those interested in promoting improved mental health status and/or outcomes.

- *Linguistic and cultural barriers*

  Culturally competent service delivery and outreach is lacking and this can prevent individuals from seeking and obtaining appropriate care. Long-term mistrust of the "system" further exacerbates the problem. Mental health care providers do not mirror the community they serve; this creates additional barriers in understanding of cultural mores.

- *Access to services*

  No central directory of services is available to encourage the search for appropriate care. Insurance coverage is poor or nonexistent. Primary care physicians, often the only link to health care, often do not have the training and/or the time to explore and treat mental health issues. Services for early detection and prevention of mental health crises do not exist. No support is available for national or local referral systems.

Resources:

The resources for mental health care have been growing, but are not sufficient to meet the need, especially those targeted directly toward women. They are not integrated into the delivery of general health care and consequently are often funded at a significantly lower level. A list of some selected resources is included in Appendix III.

Policy Recommendations:

1. *Integrate mental health into the delivery of general health care* with tools for screening, assessment, and intake. Identify depression and anxiety as factors in overall well-being. Create a communications channel and closer collaboration between physical and mental health practitioners.

2. *Create a collaborative public/private partnership of professionals and consumers* to design an education campaign to address the perceived stigma attached to mental health services and diseases and to encourage individuals to seek help. Draft

promotions in languages that are meaningful for the target group, and provide for gender-specific messages.

3. *Promote education and training about mental health* across a broad spectrum of health and social services. Ensure that the training and services are culturally competent and account for ethnic, religious and cultural differences and languages. Review curriculum in educational settings and ensure that the needs of women with mental health issues are identified.

Action Steps:

- Convene a Task Force to identify appropriate and practical assessment tools for mental health facilities and for use by primary care practitioners
- Design educational materials such as videos, posters, comic books, and other mixed media to ensure delivery of effective messages. Develop materials for special populations, including Braille, large print, and translated materials.
- Conduct outreach to community based organizations, faith-based groups and other agencies and locations where women are prone to congregate to provide information, education and training.
- Develop materials to help consumers identify when family or friends are in need of help, methods to reach out to these individuals, and referral sources for them to utilize.

VI. VIOLENCE AGAINST WOMEN

Violence against women is a broad category that transcends and encompasses physical and mental health, addictions, chronic illness and Maternal and Child Health, as well as the general well-being of women. The topic includes a multitude of issues, including domestic violence, sexual assault, child sexual abuse, elder abuse, substance abuse, and minority health.

Problems:

- *Lack of services*

  Low-income housing is not available to provide women an alternative to remaining in a violent atmosphere. Budget cuts are endangering even the sparse resources currently in place. Many women lack adequate insurance to obtain health care needed are a result of violence and women who do not participate in the prosecution of an abuser are often denied additional services.

- *Professional education should be expanded*

  Health professionals, community agencies and public/private advocates need education and training about the appropriate response to violence and available resources for referral. Education and resources should be provided in a culturally competent environment. Law enforcement officers are especially in need of training about the scope of violence, methods of response, and referral to resources. Teachers and school administrators should be trained to identify children at risk. Health professionals need training in coping with their own personal feelings about the trauma they encounter.

- *Programs are often not culturally competent or linguistically diverse*
  Services targeted to specific population groups are not available, including racial, ethnic, religious and cultural minorities, disabled women, children and older women. Bilingual care providers with experience with domestic violence and sexual assault are needed. Outreach in understandable terms is necessary for children, for whom early intervention may prevent greater victimization, and to prevent the cycle of the abused becoming an abuser.

- *Long-term follow up is needed*
  Women who are victims of violence may need long-term care for chronic diseases, mental health issues or other concerns relative to adjustment, not currently provided in most settings. Appropriate alternative health care is often not an option provided.

- *Social stigma and perception*
  Women from middle and upper income categories are reluctant to ask for help, and may not qualify for some of the services that do exist. A stigma remains relative to domestic violence.

- *Research is needed*
  Information and valid data is needed about what constitutes a successful program for offenders, how to prevent abused children from becoming abusers, and the impact of the urban culture on violence against women. Timely and accurate statistics are needed to provide appropriate planning and accountability. In addition, models for ongoing parenting and relationship education are needed.

Resources:

While adequate resources do not currently exist, a number of services and organizations do provide information, referral and education about violence. Some of these sources can be found in Appendix III.

Policy Recommendations:

1. *Develop a comprehensive education and training program* that would encompass a number of constituencies:
   - Children in school, with a focus on prevention and early identification of risk;
   - Health care, law enforcement and social service professionals, with training in domestic violence and sexual assault required as a condition of licensure where appropriate; and
   - Health care and community organizations, focused on the impact of the abused and survivors on the society.

2. *Create an innovative and energetic public awareness campaign* about the impact of violence against women. Focus on underserved, diverse populations, the disabled, and others of special need by ensuring appropriate language and targeted messages. Recruit non-traditional partners, nationally and locally, to ensure that the message is

effective. Promote a paradigm shift in thinking about violence and its sources, and efforts to ameliorate it. Create a community attitude that repudiates violence in family life.

3. *Recruit men to be active participants in programs to reduce or eradicate violence against women.*

Additional Recommendations:

- Advocate for legislation to address the need for support and services for victims of domestic violence and sexual assault.
- Develop goals and objectives related to violence against women to be included in the Healthy New Jersey 2010 document.
- Develop programs that ensure equitable and universal access to services for women who are victims of violence.
- Participate actively with children's services programs to help professionals understand the impact of violence on children and attempt to break the cycle of abused children becoming adult abusers.
- Develop measurable outcomes for community education programs.

Action Steps:

- Design a data collection system and establish benchmarks for measuring progress in diminishing the violence against women and providing appropriate services.
- Develop a comprehensive and coordinated resource guide for consumers, health professionals and law enforcement offices.
- Search for and adapt model initiatives for reducing violence against women, especially those that apply the outcome of research to clinical settings.
- Incorporate violence against women into the general dialogue on women's health at all levels.
- Seek collaboration partners, including non-traditional settings such as beauty salons, community organizations, members of the media, businesses, interested men's groups, faith-based organizations and other sources of access to women.
- Advocate for legislation that would include educational requirements for licensure of health professionals, for improving school curricula and for training of victim's advocates. Coordinate development of appropriate educational materials.
- Promote a mandate for appropriate and sensitive screening and intervention protocols for law enforcement agencies, health facilities and social service agencies.
- Encourage inclusion of family violence prevention in school curriculum for young children through high school. Focus on the language and promote broad and uniform understanding of common terms related to violence.
- Expand the range and types of services available to all women who are victims of violence, encompassing all socioeconomic, cultural, racial, ethnic, religious and special populations.

PROCEEDINGS SUMMARY

"Working Together for Comprehensive Women's Health" clearly met its articulated goals. The program brought together a diverse group of committed and energetic health care professionals and advocates to consider the future of women's health, and to launch the *New Jersey Office on Women's Health.* Conference planners and participants acknowledged the overwhelming nature of the task, and the ambitious agenda in light of the time constraints. Nonetheless, the conference participants achieved a considerable, and significant outcome in raising consciousness about critical issues for women's health and designing an initial blueprint for addressing them.

A number of themes resonated throughout the day within all of the work groups:

- Delivering high quality and responsive health care to women is a collaborative process and all relevant stakeholders should be included.
- Well-designed and ongoing education for the public and for health professionals is needed which targets the specific needs of women throughout the life span and in all settings.
- The diverse concerns of special populations, including cultural, religious, ethnic, disabled, alternative lifestyles, older women, children, and teens should be addressed and training offered to ensure culturally competent, sensitive and focused services.
- New models of direct services based on valid data and relevant science are needed in all realms of care.
- Ensuring universal access to services, and the availability of a comprehensive directory of services were considered high priorities.
- Advocacy for legislative, regulatory and funding initiatives will be a key element in achieving the goals of advancing women's health in New Jersey.

A full consideration of women's health care issues will require a long term and intensive commitment by the NJOWH and every agency, organization and interested individual throughout the State. Dedicated individuals and agencies can initiate some actions immediately, including:

- Reviewing an agencies' own policies and programs to ensure that they are sensitive to and appropriate for the gender, culture and language of all constituencies, including staff members, and adopting changes and revisions as appropriate;
- Participating in local, regional and Statewide collaborative initiatives, including the Task Forces to be established by the NJOWH;
- Initiating discussion of these important issues with local, regional and statewide health planners, legislators, regulators and other organizations responsible for policy decisions and resource allocation;
- Incorporating the principles identified during the conference into behaviors in all realms of health care service.

The conference provided a robust and pace-setting launch for the new Office on Women's Health and a collaborative basis for moving the goals and objectives forward.

Edited by: Denyse L. Adler, MA, The Adler Group

APPENDICES

APPENDIX I

LEGISLATION ESTABLISHING THE OFFICE ON WOMEN'S HEALTH

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LEGISLATION ESTABLISHING THE OFFICE ON WOMEN'S HEALTH

CHAPTER 376

AN ACT establishing the Office on Women's Health in the Department of Health and Senior Services.

BE IT ENACTED *by the Senate and General Assembly of the State of New Jersey:*

C.26: 1A-123 Findings, declarations relative to women's health.

1. The Legislature finds and declares that: women tend to live seven years longer than men and are at greater risk of having chronic diseases; approximately 75% of residents in New Jersey's long-term care facilities are women; approximately 19%, or 500,000 women 19 through 64 years of age in the State have no health insurance; women of color experience a shorter life expectancy, higher maternal and infant mortality, and more chronic disease; and it is important to promote the prevention and early detection of diseases in women and the equality of care, treatment and rehabilitation for women when they become ill.

The Legislature further recognizes that: heart disease is the leading cause of death for women, however, women with heart disease are not diagnosed or treated as early or as aggressively as men, and the classic risk profile for cardiovascular disease is based on a male model of disease; breast cancer is the leading cause of death in women between the ages of 35-50; New Jersey has higher than average rates for breast cancer and the State ranks 25th among all states for breast cancer screening; there remains a tremendous need for education and information regarding breast cancer symptoms, self-evaluation, routine mammography, prevention programs and access to services; nearly one fourth of pregnant women do not receive adequate prenatal care; women constitute the fastest growing group of people with AIDS in New Jersey; and domestic violence is a major health problem for women nationally and in this State.

Therefore, it is necessary to create a special office to focus exclusively on these crucial health concerns facing the women in New Jersey.

C.26: 1A-124 Office on Women's Health.

2. There is established the Office on Women's Health in the Department of Health and Senior Services. The office shall:

VII. Provide grants to community-based organizations to conduct special research, demonstration and evaluation projects on women's health concerns;

VIII. Develop and implement model public and private partnerships throughout the State for health awareness campaigns and to improve the access, acceptability and use of public health services;

IX. Serve as an information and resource center for women's health information and data;

X. Function as an advocate for the adoption and implementation of effective measures to improve women's health;

XI. Convene such task forces of experienced, knowledgeable persons on specific women's health issues as the director deems appropriate; and

XII. Review the programs of the Departments of Health and Senior Services, Human Services, Community Affairs and Education and any other department of State government, as appropriate, that concern women's health and make recommendations to the departments that will enable them to better coordinate and improve the effectiveness of their efforts.

C.26:1A-125 Appointment of director.

3. The Commissioner of Health and Senior Services shall appoint a director for the office who shall serve at the pleasure of the commissioner during the commissioner's term of office and until the appointment and qualification of the director's successor. The director shall devote his entire time to the duties of the position and shall receive a salary as provided by law.

C.26:1A-126 Duties of office.

4. The office shall:
   a) Apply for and accept any grant of money from the federal government, private foundations or other sources, which may be available for programs related to women's health;
   b) Serve as the designated State agency for receipt of federal funds specifically designated for women's health programs; and
   c) Enter into contracts with individuals, organizations, and institutions necessary for the performance of its duties under this act.

C.26:1A-127 Women's Health Advisory Commission.

5. There is established a Women's Health Advisory Commission.

The commission shall consist of nine members, including the Commissioner of Health and Senior Services or his designee, who shall serve ex officio, and eight public members who are residents of the State and who shall be appointed as follows: one member who is a health care professional shall be appointed by the President of the Senate; one member who is a health care professional shall be appointed by the Speaker of the General Assembly; and six members, at least two of whom are health care professionals, at least one of whom represents health care facilities, at least one of whom represents the health insurance industry, and at least one of whom is a woman with a disability, shall be appointed by the Governor with the advice and consent of the Senate. No less than five of the public members shall be women.

The term of office of each public member shall be three years, but of the members first appointed, two shall be appointed for a term of one year, three shall be appointed for a term of two years and three shall be appointed for a term of three years. A member shall hold office for the term of his appointment and until his successor has been appointed and qualified. All vacancies shall be filled for the balance of the unexpired term in the same manner as the original appointment. A member of the commission is eligible for reappointment.

The public members of the commission shall not receive any compensation for their services, but shall be reimbursed for the actual and necessary expenses incurred in the performance of their duties as members of the commission, within the limits of funds available to the commission.

The members of the commission shall annually elect a chairman and a vice-chairman from among the public members and may select a secretary, who need not be a member of the commission.

The Office on Women's Health in the Department of Health and Senior Services shall provide staff and assistance which the commission requires to carry out its work.

C.26:1A-128 Duties of commission.

6. The commission shall:
   a) Review and make recommendations to the Office on Women's Health on any rules, regulations and policies proposed by the office;
   b) Advise the office on the awarding of grants and development of programs and services required pursuant to this act;
   c) Advise the office on the needs, priorities, programs and policies relating to women's health in this State; and
   d) Provide any other assistance to the office, as may be requested by the director.

The commission may accept from any governmental department or agency, public or private body or any other source grants or contributions to be used in carrying out its responsibilities under this act.

.26:1A-129 Annual report to Legislature, Governor.

7. The Office on Women's Health shall report annually, by September 1 of each year, to the Legislature and the Governor on the activities of the office, including the grants made to community-based organizations, any public or private partnerships that the office has developed or implemented, and any task forces on specific women's health issues that the office has convened. The office may include in the report any recommendations for administrative or legislative action that it deems appropriate.

C.26:1A-130 Assistance, services available to the office.

8. The Office on Women's Health is entitled to call to its assistance, and avail itself of, the services of employees of any State, county or municipal department, board, bureau, commission or agency as it may require and as may be

available to it for its purposes. All departments, agencies and divisions are authorized and directed, to the extent not inconsistent with law, to cooperate with the Office on Women's Health.

C.26:1A-131 Rules, regulations.

9. The Commissioner of Health and Senior Services shall adopt rules and regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) to carry out the purposes of this act.

10. This act shall take effect on the 60th day after enactment. Approved January 8, 2002.

APPENDIX II

PROGRAM AGENDA

APPENDIX II

PROGRAM AGENDA

Welcome:

Carolyn Holmes, Deputy Commissioner
New Jersey Department of Health and Senior Services
Representing Clifton R. Lacy, MD,
Commissioner of the Department of Health and Senior Services

National Perspective on Women's Health

Carolyn Lofgren
Advisor for Regional Women's Health Issues
U.S. Department of Health and Human Services

Regional Perspective

Sandra Estepa
Regional Program Consultant for Women's Health
Region II U.S. Public Health Service
Office on Women's Health

New Jersey Perspective

Celeste Andriot Wood
Assistant Commissioner
Division of Family Health Services
New Jersey Department of Health and Senior Services

Charge to the Work Groups:

Doreleena Sammons-Posey, Program Manager
NJ Cancer Education and Early Detection
Division of Family Health Services
New Jersey Department of Health and Senior Services

Workshops:

- **Health Promotion**

Facilitators: *Claude Colimon*
Consultant, Minority Health
Maternal Child Health Bureau

Cynthia Collins, M.S., R.D.
Adolescent Health Coordinator
Maternal and child and Community Health
Child & Adolescent Health Program
Division of Family Health Services
New Jersey Department of Health and Senior Services

Presenter: *Linda Thurston*
Health and Fitness Consultant
ACSM Exercise Specialist, YMCA Personal Trainer

- **Mental Health**

Facilitators: *Joan Monaghan, MS, RN, APN*
Hackensack University Medical Center

Juneau Mahan Gary, Psy.D
Kean University
Counselor Education Program

Presenter: *Monica Indart, Psy.D.*
Psychologist*, Private Practice*

- **Violence** Against Women

Facilitators: *Carol Vasile*
Supervisor, Office on the Prevention of Violence Against Women
Division on Women, New Jersey Department of Community Affairs

Judith Goldberg
Jewish Renaissance Foundation

Presenters: *Sandy Clark*
Associate Director, NJ Coalition for Battered Women

Alana Goebel
Assistant Director, NJ Coalition Against Sexual Assault

- **Addictions/HIV/STD'S**

Facilitators: *Sindy Paul, MD, MPH*
Medical Director
Division of AIDS Prevention and Control
New Jersey Department of Health and Senior Services

Judith Morales
Perinatal Addictions Coordinator
Northern NJ MCH Consortium

Presenters: *Patricia A. Nisler, MA*
Manager
Life Improving Network to the Community (LINC)
Visiting Nurse Association of Central Jersey

Clara Gregory
Coordinator
Office of Special Projects and Initiatives
Division of AIDS Prevention and Control
New Jersey Department of Health and Senior Services

- **Chronic Illnesses**

Facilitators: *Dr. Nancy S. Redeker*
Associate Professor
Rutgers College of Nursing

Mary Ann Reiter
Division of Family Health Services
New Jersey Department of Health and Senior Services

- **Maternal and child Health**

Facilitators: *Shirley Smith, RN, MS*
MCH Regional Nurse Consultant
Maternal and child Health Bureau, Region II
Health Resources and Services Administration
US Department of Health and Human Services

Barbara May, BSN RN
Director, Prevention Programs
Southern New Jersey Perinatal Cooperative

Presenters: *Shirley White Walker, RN, M. ED, CNM*
Director of Patient Services/Chief Midwife
Plainfield Health Center

Yvonne Wesley, RN, PhD
Vice President Community Relations
Meridian Health Systems

Lydia Burgos, RN, SMS
Director, Women's Health Services
North Hudson Community Action Health Center

Summation and Next Steps

Peri L. Nearon, MPA
Coordinator, Office on Women's Health
Division of Family Health Services
New Jersey Department of Health and Senior Services

APPENDIX III

RESOURCES AND RELATED ORGANIZATIONS

APPENDIX III

RESOURCES AND RELATED ORGANIZATIONS

Many of the workshops identified specific or general resources relative to their topics. Some of the resources are listed by type of organization; others are more specific citations or web sites. All of the participants agreed that a more comprehensive, inclusive directory of resources was an important action step for the development of policies and services for Women's Health.

- **MATERNAL AND CHILD HEALTH**

Organizations

- New Jersey Primary Care Association
  - List of Federally Qualified Health Centers and Homeless Projects
- Regional Maternal and child Health Consortia
  - Licensed by NJDHSS (list attached)
- March of Dimes, New Jersey Chapter
  - Focus on Prematurity, Birth Defects Prevention, Improved Birth Outcome
- UMDNJ School of Public Health
  - Institute for the Elimination of Racial Disparities
    - Diane R. Brown, PH.D. Browndi@umdnj.edu
    - www.umdnj.edu

Other Resources

- Office of Women's Health, HRSA
  - Senior Advisor for Women's Health: Betty Hambleton 301-443-8695
  - Bright Futures for Women's Health and Wellness
    - Guidelines for health care
    - www.hrsa.gov/womenshealth
- Division of Perinatal Systems and Women's Health, HRSA
    - www.mchb.hrsa.gov
- Wise Women Project CDC
    - www.cdc.gov/wisewoman
- National Academy of Sciences
  - Report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care"
    - www.national-academies.org

Community Resources that Provide MCH Services

- Women, Infants and Children Agencies
- Family Planning Centers
- Hospitals
- Breast Care Centers
- Women's Shelters
- Immigration Centers
- Project Law
- Faith-based organizations
- NJDHSS and County Health Departments
- Child Care Services
- Family Services Centers
- Schools

- County-based Special Child Health Services
- NJDHSS Division of Addictions Services re: substance abuse treatment providers

- **HEALTH PROMOTIONS**

Federal Organizations:

- Centers for Disease Control and Prevention
- Department of Health and Human Services
- United States Department of Agriculture
- National Center for Standards for Culturally and Linguistically appropriate Services in Health Care

Other Organizations:

- New Jersey Department of Health and Senior Services: Local Information Network Communication System (LINCS)
- Local Recreation Departments
- The Governor's Council on Physical Fitness and Sports
- Project Healthy Bones
- American Cancer Society
- American Heart Association
- Corporate Wellness Offices
- American College of Sports Medicine
- National Black Women's Health Project
- New Jersey Cancer Control Plan
- New Jersey Office on Minority Health data base
- YMCA/YWCA
- State Colleges and Universities
- University of Medicine and Dentistry of New Jersey School of Public Health, Center for Excellence for Women
- Local Health Officers
- NJ Chapter, Public Health Association, Society of Public Health Educators, NJ Nurses Association, etc.
- New Jersey Public Health Nurse Administrators
- Robert Wood Johnson Foundation
- Managed Care Organizations
- Private recreation facilities

- **CHRONIC ILLNESS**

The Work Group identified the need for a catalogue of such resources. Some of the groups include:

- American Heart Association
- New Jersey Diabetes Association
- Asthma Coalition
- American Cancer Society
- Women's Heart Foundation

- **ADDICTIONS, HIV/AIDS, SEXUALLTY TRANSMITTED DISEASES**

Addictions

- Methadone clinics
- Substance abuse county councils
- Inpatient/outpatient centers
- Support groups (AA, 12 step groups, Alanon, Gamblers Anonymous)
- Science-based strengthening families
- New Jersey Department of Health and Senior Services, Division of Addiction Services
- Hot Links

HIV/AIDS, Sexually transmitted diseases

- Federal, state and local hotlines
- Counseling, prevention, testing and treatment programs
- Housing and social service programs
- Medications
- Perinatal and prison initiatives

- **MENTAL HEALTH**

- NJ Department of Human Services, Division of Mental Health
- Community Mental Health Centers
- Mental Health Association
- County Mental Health Board
- Free-standing private, non-profit mental health facilities
- Crisis and Suicide Centers/Hotlines
- Self-Help Clearing House
- Asian-American Association for Human Services
- 12 step programs for addictions
- Specific disease-related support and information groups
- Faith-based organizations
- Community-based and ethnic organizations
- Professional associations
- Schools, colleges, universities
- Social Service agencies, individual practitioners and organizations
- Web sites
- Women's Health Programs

- **VIOLENCE AGAINST WOMEN**

- Women's shelters and hotlines
- Sexual Assault Nurse Examiner
- Sexual Assault Response Team
- Free legal and counseling programs
- Planned parenthood and other health care clinics
- Independent living centers
- New Jersey Coalition for Battered Women (NJCBW)

- Relationships and Power (RAP) Curriculum, NJCBW
- New Jersey Coalition Against Sexual Assault
- Drug and alcohol rehabilitation resources
- NJ Department of Community Affairs, Division on Women Rape Care Programs
- Web sites and search engines
- Libraries, schools, colleges and universities
- MANAVI – group addressing domestic and sexual violence in the lives of South Asian Women
- Faith-based, spiritual, sororities, community, ethnic groups and organizations
- National Sexual and Violence Resource Center
- National Resources Center on Domestic Violence
- Domestic Violence Response Teams
- Victims of Violent Crimes Compensation Board
- Prosecutors Office
- American Friends – group dedicated to helping battered women who are immigrants, undocumented or in status transition
- Teen Prevention Education Program
- Legal Services of New Jersey: Domestic Violence Projects
- "Gear Up" – California model Peer to Peer program

APPENDIX IV

CONFERENCE PARTICIPANTS

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CONFERENCE PARTICIPANTS

Name	Affiliation
Adler, Denyse	Adler Group Health Consultants
Ahmad Khanlou, Parvin	New Jersey Department of Health and Senior Services
Allarde, Cora	Paterson Community Health Center
Amaya-Fernandez, Elizabeth	National Latin Health center
Anderson, Linda	New Jersey Department of Health and Senior Services
Andrews, Barbara	New Jersey Department of Health and Senior Services
Andriot Wood, Celeste	New Jersey Department of Health and Senior Services
Asare, Lisa	New Jersey Department of Health and Senior Services
Atwood, Bear	New Jersey Division on Women
Bagnal, Maggie	Rape Crisis Services, Cumberland County Guidance Center
Barrett, Jennifer	New Jersey Hospital Association
Belgrave, Dr. Gerald	Newark Community Health
Bobo, Irving	Institute for Human Development
Boehm, Abbie	Planned Parenthood/ Trenton
Booker , Shirley	
Burgos, Lydia	North Hudson Community Health
Caldra, Carol	American Lung Association of NJ
Cappelli, Mimi	New Jersey SNA
Carter, Alison	NJ Commission on Aging
Chu, Jennifer	International Institute
Clark, Sandy	NJ Coalition for Battered Women
Colimon, Claude	Maternal and Child Health Bureau
Collins, Cynthia	New Jersey Department of Health and Senior Services
Copeland, Margaret	New Jersey Department of Health and Senior Services
Copes, Marie	
Culp, Karen	New Jersey Department of Health and Senior Services
Cummings, Lisa	New Jersey Department of Health and Senior Services
Davis, Zupenda	New Jersey Primary Care Association
Diaz, Ritza	Essex Substance Abuse
Downey, Anne	Virtua Home Care Community
Dultz, MD. FACS, Rachel	Princeton Surgical Associates
Elsworth, Mary Ann	New Jersey Department of Health and Senior Services
Esposito, Courtney	Womanspace, Inc.
Estepa, Sandra	U.S. Public Health Service
Fauntleroy, Karen	Southern NJ Family Medical Centers, Inc.
Field, Nancy	New Jersey Department of Health and Senior Services
Florentino, M. Claire	Christ Hospital
Francese, Tracy	Passaic County Women's Center
Franzione, Anita	PRONJ
Freenlers, Gwen	
Ganges , Larry	New Jersey Department of Health and Senior Services
Gilliard, Jennifer	
Giordano, Michele	Planned Parenthood/ Trenton
Glass, Dr. Phillip	
Goebel, Alana	NJ Coalition Against Sexual Assault

Name	Affiliation
Goldberg, Judith	Jewish Renaissance Foundation
Gray, June	Children's Health
Gregory, Clara	New Jersey Department of Health and Senior Services
Grirutey, Naiocet	
Hamilton, Grace	New Jersey Divison on Women
Harris, Julia	RPC/Moc Inc
Hart, Grace	Good News Home for Women
Herman, Karen	Rutgers University
Herron, Suzanne	Southern NJ Perinatal Cooperative, Inc.
Hewitt, Lynne	VNA Central NJ
Hogarty, Marie	Maternal and Child Health Network
Holder-Moseley, Roberta	Federal Region II, HRSA
Holsinger, Valerie	
Hubbard, Annette	Concerned Black Nurses of New Jersey
Indart, PsyD, Monica	
Jaker, Michele	Planned Parenthood
Johnson, Linda	Brava/NJCEED- Capital Health System
Jones, Deborah	New Jersey Department of Health and Senior Services
Kelkar, Maneesha	
Kidder, Rosemary	New Jersey Department of Health and Senior Services
Killian, Mary Lou	Henry J Austin Health Center, Inc.
Kinkle, Suzanne	Southern NJ Perinatal Cooperative Inc
Knight, Peg	New Jersey Department of Health and Senior Services
Kohlhepp, Carolyn	NJ Family Planning League, Inc.
Krupka , Patricia	NJ DD Council
Lachenmayr, Susan	New Jersey Department of Health and Senior Services
Lockerman, Anita	
Lodge, Mary	Southern NJ Perinatal Cooperative, Inc.
Lofgren, Carolyn	U.S. Department of Health and Human Services
Macionis, Pat	NJ Department of Human Services
Mahan Gray, PsyD, Juneau	Kean University
Mainan, Nora	
Martin, Bernadette	New Jersey Department of Health and Senior Services
Martin, Grace	G.G. Martin Enterprises
Martin, Rose Marie	New Jersey Department of Health and Senior Services
Mason-Reese, Charlene	City of Elizabeth, Department of Health and Human Services
Matnani, Nora	
May, Barbara	Southern NJ Perinatal Cooperative Inc.
McAndrew, Rosemary	UMDNJ/RWJMS
McDonald, Annette	Domestic Abuse Services
Meyer, Michele	Southern NJ Perinatal Cooperative Inc.
Miller, Sharon	New Jersey Division on Women
Monaghan, Joan	Hackensack University Medical Center
Morales, Judith	Northern NJ MCH Consortium
Moroso, Sandee	Prevention Links, Inc.
Mozee, Cynthia	New Jersey Department of Health and Senior Services
Napier, Phyllis	
Nearon, Peri	New Jersey Department of Health and Senior Services

Name	Affiliation
Nisler, Patricia	
Noyes, Liz	Mercer Planned Parenthood
Oberman, Alan	Catholic Charities, Asbury Park
Oyenkola, Victoria	Essex Substance Abuse
Parker, Rasheeda	Patterson Community Health Center
Paul, MD, Sindy	New Jersey Department of Health and Senior Services
Pinzon, Irene	
Pizzute, Lydia	Bergen County Rape Crisis Center
Portales, Maria	Community Health Promotions
Primas-Taylor, Cynthia	
Pruden , Jennifer	Union County Rape Crisis Center
Redeker, Dr. Nancy	Rutgers College of Nursing
Reilly, Phyllis	UMDNJ-UBHE
Reiter, Mary Ann	New Jersey Department of Health and Senior Services
Remer, Tara	St. Joseph University Healthcare
Reynolds, Alice	Constella Health Sciences
Rodriguez, Dr. Gloria	New Jersey Department of Health and Senior Services
Russo, Kathleen	New Jersey Department of Health and Senior Services
Samarya-Timm, Michelle	Franklin Township Department of Health
Sammons-Posey, Doreleena	New Jersey Department of Health and Senior Services
Schwarz, Sandra	New Jersey Department of Health and Senior Services
Smith, Natalie	
Smith, Shirley	NY HRSA Regional Division
Sparber, Beatrice	Health Educator
Speller, Sylvia	Southern NJ Perinatal Cooperative, Inc.
Stein, Susan	Horizon Health Center
Stickle-Pironti, Denise	CNJMCHC
Taylor, Laura	Planned Parenthood
Teffenhart, Patricia	
Teman, Bonnie	New Jersey Department of Health and Senior Services
Terron , Irma	Bayonne Medical Center
Thomas, Erica	Southern NJ Perinatal Cooperative, Inc.
Thurston , Linda	
Toulson, Gloria	
Trautwein, Anna	Saint Peter's Hospital
Vasile, Carol	NJ Division on Women
Walker, Molly	Horizon Health Center
Wesley, Dr. Yvonne	Meridien Health System
White-Walker, Shirley	Plainfield Neighborhood Health Services Corp.
Williams, Rose	NJ Coalition for Battered Women
Wilson, Evelyn	